Jim Doyle
Governor

Roberta Gassman
Secretary

Frances Huntley-Cooper
Division Administrator

State of Wisconsin
Department of Workforce Development

WORKER'S COMPENSATION
201 East Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Imaging Server Fax: (608) 260-2503
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: dwddwc@dwd.state.wi.us

October 6, 2003

TEST INSURER 1
C/O TEST INSURER 1
ONE MAIN ST
MADISON WI 53703

WC CLAIM NO: 9999-999999
INJURY DATE: 05/01/98
EMPLOYEE: SIMPLE, SAMPLE
EMPLOYER: SAMPLE EMPLOYER INC
INSURER NO: 094CBD6S8646

IF YOU CALL OR WRITE US
PLEASE USE WC CLAIM NO.

We are making an annual follow-up for this permanent total injury. Please answer the questions below and return this form or a photocopy.

1. Has there been any change in this employee's condition? _____ Yes _____ No
2. Has there been any change of address? If yes, please write the new address below.

3. Enter amount paid through for the following:
   - Temporary Total Disability $_____
   - Permanent Partial Disability $_____
   - Permanent Total Disability $_____
   - Supplemental Benefits $_____
   - Attorney Fees $_____
   - Medical Expenses $_____
   - List any other payments. $_____

Completed by: _____ Date: _____

WKC-13052-E (N. 03/2002) AU03